CLIENT REGISTRATION FORM DAAS 101 (Short Form)

NC Department of Health and Human Services • Division of Aging and Adult Services

Section I: Required for all clients

Check the applicable category or categories below and follow corresponding directions.

- HCCBG – congregate nutrition (180), congregate supplemental meals (182), NSIP-only congregate meals (181) **Sections I, II, and VII only**
- HCCBG – general (250) or medical (033) transportation complete **Sections I and VII only**

Service Codes _____ _____

Region Code_____ **Provider Code**_____

1. Client Status: *Check the appropriate box. More than one box may be appropriate.* **Date**

- ☐ New Registration/Activate (complete all per instructions above) _____
- ☐ **Waiting for Service:** service codes: ____ ____ ____ (complete Section I - unit based services only) _____
- ☐ Inactive ☐ applies to client/caregiver OR ☐ applies to care recipient _____
  - ☐ adult care home/assisted living
  - ☐ alternative living arrangement
  - ☐ death
  - ☐ hospitalization
  - ☐ nursing home placement
  - ☐ moved
  - ☐ improved function/need eliminated
  - ☐ service not needed/wanted
  - ☐ illness
  - ☐ other (specify) _____
- ☐ Change (complete Section I, Items 2, 4, 5 and any changed items.) _____

2. Name Last | First | M.I.

4. Last 4 Digits SSN _____ _____ _____ _____

3. Street Address Line 1

5. Date of Birth ____ ____ ____ (MM DD YYYY)

☐ **Special Eligibility** (under age 60)

Mailing Address Line 2

6. Phone # _____ - _____ - _____

☐ No phone

City | State | Zip | County

7. Sex *(check one)*
- ☐ Female
- ☐ Male

8. At/Below Poverty Level *(check one)*
- ☐ Yes
- ☐ No

9. Marital Status *(check one)*
- ☐ single (never married)
- ☐ married
- ☐ single (divorced/widowed)
- ☐ refused to answer

10. Household size *(check one)*
- ☐ lives alone
- ☐ 2 in home
- ☐ 3 or more in home
- ☐ group/shared home
- ☐ refused to answer

11. Race *Ask: What is your race?*

	Check one race which client most closely identifies	*Check all that apply*
a. Black or African-American	☐	☐
b. Asian	☐	☐
c. American Indian or Alaska Native	☐	☐
d. White	☐	☐
e. Native Hawaiian/other Pacific Islander	☐	☐
f. Unknown/refused	☐	☐
g. Other (specify)		

12. Hispanic/Latino *(check one)*
Ask: Are you of Hispanic or Latino origin?

☐ Yes ☐ No

(a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture of origin, regardless of race)

13. Primary Language Spoken
Ask: What language do you speak in your home?

Language_____

14. Overall Functional Status: ☐ Well ☐ At-risk ☐ High Risk *(If Section IV is required, do not complete.)*

Section II: Required only for clients of HCCBG congregate meals, congregate supplemental meals, or NSIP-only meals.

15. Nutrition Health Score		Refused to Answer
a. Do you have an illness or condition that made you change the kind and/or amount of food you eat?	☐ Yes ☐ No	☐
b. How many meals do you eat per day?	#	☐
c. How many servings of fruit per day?	#	☐
d. How many servings of vegetables per day?	#	☐
e. How many servings of milk/dairy products per day?	#	☐
f. How many drinks of beer, liquor, or wine do you have every day or almost every day?	#	☐
g. Do you have tooth/mouth problems that make it hard for you to eat?	☐ Yes ☐ No	☐
h. Do you always have enough money or food stamps to buy the food you need?	☐ Yes ☐ No	☐
i. How many meals do you eat alone daily?	#	☐
j. How many prescribed drugs do you take per day?	#	☐
k. How many over-the-counter drugs do you take per day?	#	☐
l. Have you lost or gained 10 or more pounds in the past 6 months without trying?		
Did you gain weight?	☐ Yes ☐ No	☐
Did you lose weight?	☐ Yes ☐ No	☐
m. Are you physically able to:		
Shop for yourself?	☐ Yes ☐ No	☐
Cook for yourself?	☐ Yes ☐ No	☐
Feed yourself?	☐ Yes ☐ No	☐

Section VII: REQUIRED FOR ALL CLIENTS.

I, the client, understand the information contained on this form will be kept confidential unless disclosure is required by court order or for authorized federal, state or local program reporting and monitoring. I understand that any entitlement I may have to Social Security benefits or other federal or state sponsored benefits shall not be affected by the provision of the aforementioned information. My signature authorizes the providing agency to begin the service(s) requested.

DATE:_____**CLIENT SIGNATURE:**_____

DATE:_____**AGENCY EMPLOYEE SIGNATURE:**_____

EMERGENCY CONTACT PERSON

Name:_____

Phone (day):_____-_____-_____ (evening):_____-_____-_____

☐ Refused to provide emergency contact information

Provider Use Only:

Registration Update _____/_____/_____ Staff Initials_____

Registration Update _____/_____/_____ Staff Initials_____

Registration Update _____/_____/_____ Staff Initials_____